General

Guideline Title

Providing quality family planning services: recommendations of CDC and the U.S. Office of Population Affairs.

Bibliographic Source(s)

Gavin L, Moskosky S, Carter M, Curtis K, Glass E, Godfrey E, Marcell A, Mautone-Smith N, Pazol K, Tepper N, Zapata L, Centers for Disease Control and Prevention (CDC). Providing quality family planning services: recommendations of CDC and the U.S. Office of Population Affairs. MMWR Recomm Rep. 2014 Apr 25;63(RR-04):1-54. [364 references] PubMed

Guideline Status

This is the current release of the guideline.

Recommendations

Major Recommendations

Note from the National Guideline Clearinghouse (CDC) and the Centers for Disease Control and Prevention (CDC): Sixteen core recommendations that were considered by the Expert Working Group (EWG) are presented below. A detailed discussion of the recommended practices is presented in the original guideline document. Additionally, Tables 2 and 3 in the original guideline document provide checklists of family planning and related preventive health services for women and men, respectively.

Definition of Family Planning Services

Recommendation: Primary care providers should offer the following family planning services: contraceptive services for women and men who want to prevent pregnancy and space births, pregnancy testing and counseling, help for clients who wish to achieve pregnancy, basic infertility services, sexually transmitted disease (STD) services and preconception health services to improve the health of women, men, and infants.

Quality of evidence: A systematic review was not conducted; the recommendation was made on the basis of federal statute and regulation, CDC clinical recommendations and expert opinion.

Potential consequences: Adding preconception health services means that more women and men will receive preconception health services. The recommended services also will promote the health of women and men even if they do not have children. The human and financial cost of providing preconception health services might mean that fewer contraceptive and other services can be offered in some settings.

Rationale: Services to prevent and achieve pregnancy are core to the federal government's efforts to promote reproductive health. Adding preconception health as a family planning service is consistent with this mission; it emphasizes achieving a healthy pregnancy and also promotes adult health. Adding preconception health is also consistent with CDC recommendations to integrate preconception health services into primary care platforms. All seven EWG members agreed to this recommendation.

Preconception Health — Women

Recommendation: Preconception health services for women include the following screening services: reproductive life plan; medical history; sexual health assessment; intimate partner violence, alcohol, and other drug use; tobacco use; immunizations; depression; body mass index (BMI); blood pressure; chlamydia, gonorrhea, syphilis, and human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS); and diabetes. All female clients also should be counseled about the need to take a daily supplement of folic acid. When screening results indicate the presence of a health condition, the provider should take steps either to provide or to refer the client for the appropriate further diagnostic testing and or treatment. Services should be provided in a manner that is consistent with established federal and professional medical associations' recommendations to enable clients who need services to receive them and to avoid over-screening.

Quality of evidence: A systematic review was not conducted; the recommendation was made on the basis of CDC's recommendations to improve preconception health and health care and a review of preconception health services by an expert panel on preconception care for women.

Potential consequences: More women will receive specified preconception health services, which will improve the health of infants and women. The evidence base for preconception health is not fully established. There is a potential risk that a client with a positive screen will not be able to afford treatment if the client is uninsured and not eligible for public programs. The human and financial cost of providing preconception health services might mean that fewer contraceptive and other services can be offered.

Rationale: The potential benefits to the health of women and infants were thought by the panel to be greater than the costs, potential harms, and opportunity costs of providing these services. Implementation (e.g., training and monitoring of providers) can address the issues related to providers over-screening and not following the federal and professional medical recommendations. CDC will continue to monitor related research and modify these recommendations, as needed. Health-care reform might make follow-up care more available to low-income clients. All seven EWG members agreed to this recommendation.

Preconception Health — Men

Recommendation: Preconception health services for men include the following screening services: reproductive life plan; medical history; sexual health assessment; alcohol and other drug use; tobacco use; immunizations; depression; BMI; blood pressure; chlamydia, gonorrhea, syphilis, and HIV/AIDS; and diabetes. When screening results indicate the presence of a health condition, the provider should take steps either to provide or to refer the client for the appropriate further diagnostic testing and or treatment. Services should be provided in a manner that is consistent with established federal and professional medical associations' recommendations to ensure that clients who need services receive them and to avoid over-screening.

Quality of evidence: A systematic review was not conducted; the recommendation was made on the basis of CDC's recommendations to improve preconception health and health care and a review of preconception health services for men.

Potential consequences: More men will receive preconception health services, which might improve infant and men's health. The evidence base for preconception health is not well established and is less than that for women's preconception health. There is a risk of over-screening if recommendations are not followed. There is a potential risk that a client with a positive screen might not be able to afford treatment if the client is uninsured and not eligible for public programs. The human and financial cost of providing preconception health services might mean that fewer contraceptive and other services can be offered.

Rationale: The potential benefits to men and infant health were thought by the panel to be greater than the costs, potential harms, and opportunity costs of not providing these services. Implementation (e.g., training and monitoring of providers) can address the issues related to providers over-screening and not following the federal and professional medical recommendations. CDC will continue to monitor related research and modify these recommendations, as needed. Health-care reform might make follow-up care more available to low-income clients. All seven EWG members agreed to this recommendation.

Contraceptive Services — Contraceptive Counseling Steps

Recommendation: To help a client who is initiating or switching to a new method of contraception, providers should follow these steps, which are in accordance with the key principles for providing quality counseling: 1) establish and maintain rapport with the client; 2) obtain clinical and social information from the client; 3) work with the client interactively to select the most effective and appropriate contraceptive method for her or him; 4) provide a physical assessment related to contraceptive use, when warranted; and 5) provide the contraceptive method along with instructions about correct and consistent use, help the client develop a plan for using the selected method and for follow-up, and confirm understanding.

Quality of evidence: Twenty-two studies were identified that examined the impact of contraceptive counseling in clinical settings and met the inclusion criteria. Of the 16 studies that focused on adults or mixed populations (adolescents and adults), 11 found a statistically significant positive impact of counseling interventions with low, moderate, or unrated intensity on at least one outcome of interest; study designs included two cross-

sectional surveys, one pre-post study, one prospective cohort study, one controlled trial, and six randomized controlled trials (RCTs). Six studies examined the impact of contraceptive counseling among adolescents, with four finding a statistically significant positive impact of low intensity or moderate intensity counseling interventions on at least one outcome of interest; study designs included two pre-post studies, one controlled trial, and one RCT. In addition, five studies were identified that examined the impact of reminder system interventions in clinical settings on family planning outcomes and met the inclusion criteria; of these, two found a statistically significant positive impact of reminder systems on perfect oral contraceptive compliance, a retrospective historical nonrandomized controlled trial that examined daily reminder email messages and a cohort study that examined use of a small reminder device that emitted a daily audible beep. In addition, two studies examined the impact of reminder systems among depot medroxyprogesterone acetate (DMPA) users with one, a retrospective cohort study, finding a statistically significant positive impact of receiving a wallet-sized reminder card with the date of the next DMPA injection and a reminder postcard shortly before the next injection appointment on timely DMPA injections. Statements about safety and unnecessary medical examinations and tests are made on the basis of CDC guidelines on contraceptive use.

Potential consequences: Fewer clients will use methods that are not safe for them, there will be increased contraceptive use, increased use of more effective methods, increased continuation of method use, increased use of dual methods, increased knowledge, increased satisfaction with services, and increased use of repeat or follow-up services.

Rationale: Making sure that a contraceptive method is safe for an individual client is a fundamental responsibility of all providers of family planning services. Removing medical barriers to contraceptive use is key to increasing access to contraception and helping clients prevent unintended pregnancy. Consistent use of contraceptives is needed to prevent unintended pregnancies, so appropriate counseling is critical to ensure clients make the best possible choice of methods for their unique circumstances, and are supported in continued use of the chosen method. The principles of quality counseling, from which the steps listed in the recommendations are based, are supported by a substantial body of evidence and expert opinion. Future research to evaluate the five principles will be monitored and the recommendations modified, as needed. All seven EWG members agreed to this recommendation.

Contraceptive Services — Tiered Approach to Counseling

Recommendation: For clients who might want to get pregnant in the future and prefer reversible methods of contraception, providers should use a tiered approach to presenting a broad range of contraceptive methods (including long-acting reversible contraception [LARC] such as intrauterine devices and contraceptive implants), in which the most effective methods are presented before less effective methods.

Quality of evidence: National surveys have demonstrated low rates of LARC use overall. However, Project CHOICE has demonstrated high uptake of LARC (approximately two thirds of clients when financial barriers are removed) and a very substantial reduction in rates of unintended pregnancy. Further, a recent study of postpartum contraceptive use shows that 50% of teen mothers with a recent live birth are using LARC postpartum in Colorado, which demonstrates high levels of acceptance in the context of a statewide program to remove financial barriers.

Potential consequences: Use of LARC has the potential to help many more persons prevent unintended pregnancy because of its ease of use, safety, and effectiveness. Several questions were raised about ethical issues in using a tiered approach to counseling. First, is it ethical to educate about LARC when the methods are not all available on-site? Second, conversely, is it ethical not to inform clients about the most effective methods? In other health service areas, the standard of care is to inform the client about the most effective treatment (e.g., blood pressure medications), so the client can make a fully informed decision, and this standard should apply in this instance as well. On the basis of historic experiences, there is a need to ensure that methods always are offered on a completely voluntary and noncoercive basis. Health-care reform might make contraceptive services more available to the majority of clients.

Rationale: Providers have an obligation to inform clients about the most effective methods available, even if they cannot provide them. Further, health-care reform will reduce the financial barriers to LARC for many persons. The potential increase in use of LARC and other more effective methods is likely to help reduce rates of unintended pregnancy. All seven EWG members agreed to this recommendation.

Contraceptive Services — Broad Range of Methods

Recommendation: A broad range of methods should be available on-site or through referral.

Quality of evidence: Three descriptive studies from the review of quality improvement literature identified contraceptive choice as an important aspect of quality care.

Potential consequences: Clients will be more likely to select a method that they will use consistently and correctly.

Rationale: A central tenet of quality health care is that it be client-centered. Being able to provide a client with a method that best fits her or his unique circumstances is essential for that reason. All seven EWG members agreed to this recommendation.

Contraceptive Services — Education

Recommendation: The content, format, method, and medium for delivering education should be evidence-based.

Quality of evidence: Seventeen studies were identified that met the inclusion criteria for this systematic review. Of these, 15 studies looked at knowledge of correct method use or contraceptive risks and benefits, including side effects and method effectiveness. All but one study found a statistically significant positive impact of educational interventions on increased knowledge. These studies included six randomized controlled trials with low risk for bias.

Potential consequences: Clients will make more informed decisions when choosing a contraceptive method. More clients will be satisfied with the process of selecting a contraceptive method.

Rationale: Knowledge obtained through educational activities, as integrated into the larger counseling model, is a critically important precondition for the client's ability to make informed decisions. The techniques described in the recommendations have a well-established evidence base for increasing knowledge and satisfaction with services. This knowledge lays the foundation for further counseling steps that will increase the likelihood of correct and consistent use, and increased satisfaction will increase return visits to the service site, as needed. Four of seven EWG members agreed to this recommendation; three members did not express an opinion.

Contraceptive Services — Confirm Understanding

Recommendation: A check box or written statement should be available in the medical record that can be used to document that the client expressed understanding of the most important information about her/his chosen contraceptive method. The teach-back method may be used to get clients to express the most important points by repeating back messages about risks and benefits and appropriate method use and follow-up. Documentation of understanding using the teach-back method and a check box or written statement can be used in place of a written method-specific informed consent.

Quality of evidence: Two studies from outside the family planning literature (one cohort study and one controlled trial with unclear randomization) and a strong recommendation by members of the Technical Panel on Counseling and Education were considered.

Potential consequences: More clients will make informed decisions, adherence to contraceptive and treatment plans will improve, and reproductive and other health conditions will be better controlled.

Rationale: Asking providers to document in the record that the client is making an informed decision will increase providers' attention to this task. This recommendation will replace a previous requirement that providers obtain method-specific informed consent from each client (in addition to a general consent form). Six of seven EWG members agreed to this recommendation.

Adolescent Services — Comprehensive Information

Recommendation: Providers should provide comprehensive information to adolescent clients about how to prevent pregnancy and STDs. This should include information about contraception and that avoiding sex (abstinence) is an effective way to prevent pregnancy and STDs.

Quality of evidence: A systematic review was not conducted because other recent reviews were available that have shown a substantial impact of comprehensive sexual health education on reduced adolescent risk behavior. The evidence for abstinence-only education was more limited: CDC's Community Guide concluded that there was insufficient evidence, but the Department of Health and Human Services' Office of Adolescent Health has identified two abstinence-based programs as having evidence of effectiveness.

Potential consequences: Teens will make more informed decisions and will delay initiation of sexual intercourse. The absence of harmful effects from comprehensive sexual health education was noted.

Rationale: The benefits of informing adolescents about all ways to prevent pregnancy are substantial. Ultimately, each adolescent should make an informed decision that meets her or his unique circumstances, based on the counseling provided by the provider. Six of seven EWG members agreed to this recommendation.

Adolescent Services — Use of Long-Acting Reversible Contraception

Recommendation: Education about contraceptive methods should include an explanation that LARC is safe and effective for nulliparous women (women who have not been pregnant or given birth), including adolescents.

Quality of evidence: CDC guidelines on contraceptive use provide evidence that LARC is safe and effective for adolescents and nulliparous women.

Potential consequences: More providers will encourage adolescents to consider LARC; more adolescents will choose LARC, resulting in reduced rates of teen pregnancy, including rapid repeat pregnancy.

Rationale: LARC is safe for adolescents. As noted above, providers should inform clients about the most effective methods available. The potential increase in use of LARC and other more effective methods by adolescents is substantial and is likely to lead to further reductions in teen pregnancy. Three EWG members agreed to this recommendation; two EWG members abstained.

Adolescent Services — Confidential Services

Recommendation: Confidential family planning services should be made available to adolescents, while observing state laws and any legal obligations for reporting.

Quality of evidence: Six descriptive studies documented one or more of the following: that confidentiality is important to adolescents; that many adolescents reported they will not use reproductive health services if confidentiality cannot be assured; and that adolescents might not be honest in discussing reproductive health with providers if confidentiality cannot be assured. One RCT showed a slight reduction in use of services after receiving conditional confidentiality, compared with complete confidentiality. One study showed a positive association between confidentiality and intention to use services.

Potential consequences: Consequences might include an increased intention to use services, increased use of services, and reduced rates of teen pregnancy. However, explaining the need to report under certain circumstances (rape, child abuse) might deter some adolescent clients from using services. Further, some parents/guardians might not agree that adolescents should have access to confidential services.

Rationale: Minors' rights to confidential reproductive health services are consistent with state and federal law. The risks of not providing confidential services to adolescents are great and likely to result in an increased rate of teen pregnancies. Finally, this recommendation is consistent with the recommendations of three professional medical associations that endorse provision of confidential services to adolescents. All seven EWG members agreed to this recommendation.

Adolescent Services — Family-Child Communication

Recommendation: Providers should encourage and promote family-child communication about sexual and reproductive health.

Quality of evidence: From the family planning literature, 16 parental involvement programs (most using an RCT study design) were found to be positively associated with at least one short-term (13 of 16 studies) or medium-term (four of seven studies) outcome. However, only one of these studies was linked to clinical services; others were implemented in community settings.

Potential consequences: Consequences might include increased parental/guardian involvement and communication, improved knowledge/awareness, increased intentions to use contraceptives, and the adoption of more pro-social norms that support parent-child communication about sexual health.

Rationale: The literature provides strong evidence that increased communication between a child and her/his parent/guardian will lead to safer sexual behavior among teens, and numerous community-based programs have created an evidence base for how to strengthen parents/guardians' ability to hold those conversations. Although less is known about how to do so in a clinical setting, providers can refer their clients to programs in the community, and principles from the community-based approaches can be used to help providers develop appropriate approaches in the clinical setting. Research in this area will be monitored, and the recommendations will be revised, as needed. Four of five EWG members who provided input agreed to this recommendation; one member abstained.

Adolescent Services — Repeat Teen Pregnancy

Recommendation: Providers should refer pregnant and parenting adolescents to home visiting and other programs that have been shown to provide needed support and reduce rates of repeat teen pregnancy.

Quality of evidence: Three of four studies of clinic-based programs (using retrospective case-control cohort, ecological evaluation, and prospective cohort study designs) showed that comprehensive teen pregnancy prevention programs (programs with clinical, school, case management, and community components) were associated with both medium- and long-term outcomes. In addition, several randomized trials of community-based home visiting programs, and an existing systematic review of the home visiting literature, demonstrated a protective impact of these programs on preventing repeat teen pregnancy and other relevant outcomes.

Potential consequences: Consequences might include decreased rapid repeat pregnancy and abortion rates, and increased use of contraceptives.

Rationale: There is sufficient evidence to recommend that providers link pregnant and parenting teens to community and social services that might

reduce rates of rapid repeat pregnancy. Three of seven EWG members agreed to an earlier version of this recommendation. Other members wanted to remove a clause about prioritizing the contraceptive needs of pregnant/parenting teens because they felt that all clients should be treated as priority clients. This suggestion was adopted, but the EWG did not have a chance to vote again on the modified recommendation.

Contraceptive Method Availability

Recommendation: Family planning programs should stock and offer a broad range of U.S. Food and Drug Administration (FDA)-approved contraceptive methods so that the needs of individual clients can be met. These methods are optimally available on-site, but strong referrals can serve to make methods not available on-site real options for clients.

Quality of evidence: No research was identified that explicitly addressed the question of whether having a broad range of methods was associated with short-, medium-, or long-term reproductive health outcomes. However, as noted above, three descriptive studies from the review of quality improvement literature identified contraceptive choice as an important aspect of quality care.

Potential consequences: Consequences might include increased use of contraception and increased use of reproductive health services. It also was noted that there are sometimes high costs to stocking certain methods (e.g., intrauterine devices and contraceptive implants).

Rationale: Having a broad range of contraceptive methods is central to client-centered care, a core aspect of providing quality services. Individual clients need to have a choice so they can select a method that best fits their particular circumstances. This is likely to result in more correct and consistent use of the chosen methods. The benefits of this recommendation were weighed more heavily than the negative outcomes (e.g., additional cost). All five EWG members agreed to this recommendation.

Youth-Friendly Services

Recommendation: Family planning programs should take steps to make services "youth-friendly."

Quality of evidence: Of 20 studies that were identified, six looked at short-, medium-, or long-term outcomes with mixed designs (one group time series, one cross-sectional, three prospective cohort, and one nonrandomized trial); protective effects were found on long-term (two of three studies), medium-term (three of three), and short-term (three of three) outcomes. One of these six studies, plus 13 other descriptive studies (for a total of 14 studies), presented adolescents' or providers' views on facilitators for adolescent clients in using youth-friendly family planning services. Key factors described were confidentiality (13 of 14), accessibility (11 of 14), peer involvement (three of 14), parental or familial involvement (four of 14), and quality of provider interaction (11 of 14). Four of these studies plus one other descriptive study described barriers to clinics adopting and implementing youth-friendly family planning services.

Potential consequences: Consequences might include increased use of reproductive health services by adolescents, improved contraceptive use, use of more effective methods, more consistent use of contraception, and reduced rates of teen pregnancy. It is also likely to lead to improved satisfaction with services and greater knowledge about pregnancy prevention among adolescents. It is possible that there will be higher costs, and some uncertainty regarding the benefits due to a relatively weak evidence base.

Rationale: Existing evidence has demonstrated the importance of specific characteristics to adolescents' attitudes and use of clinical services. The potential benefits of providing youth-friendly services outweigh the potential costs and weak evidence base. All five EWG members agreed to this recommendation. Some thought that it should be cast as an example of comprehensively client-centered care, rather than an end of its own.

Quality Improvement

Recommendation: Family planning programs should have a system for quality improvement, which is designed to review and strengthen the quality of services on an ongoing basis. Family planning programs should select, measure, and assess at least one outcome measure on an ongoing basis, for which the service site can be accountable.

Quality of evidence: A recent systematic review was supplemented with 10 articles that provided information related to client and/or provider perspectives regarding what constitutes quality family planning services. These studies used a qualitative ($k = 4$) or cross-sectional ($k = 6$) study design. Ten descriptive studies identified client and provider perspectives on what constitutes quality family planning services, which include stigma and embarrassment reduction ($n = 9$); client access and convenience ($n = 8$); confidentiality ($n = 3$); efficiency and tailoring of services ($n = 6$); client autonomy and confidence ($n = 5$); contraceptive access and choice ($n = 4$); increased time of patient-provider interaction ($n = 3$); communication and relationship ($n = 3$); structure and facilities ($n = 2$); continuity of care ($n = 2$). Well-established frameworks for guiding quality improvement efforts were referenced.

Potential consequences: Consequences might include increased use by clients of more effective contraceptive methods, clients might be more likely to return for care, client satisfaction might improve, and there might be reduced rates of teen and unintended pregnancy, and improved spacing of

births.

Rationale: Research, albeit limited, has demonstrated that quality services are associated with improved client experience with care and adoption of more protective contraceptive behavior. Further, these recommendations on quality improvement are consistent with those made by national leaders in the quality improvement field. Research is either under way or planned to validate a core set of performance measures, and the recommendations will be updated as new findings emerge. All five EWG members agreed to these recommendations.

Clinical Algorithm(s)

An algorithm titled "Clinical Pathway of Family Planning Services for Women and Men of Reproductive Age" is provided in the original guideline document.

Scope

Disease/Condition(s)

- Pregnancy (intended or unintended)
- Infertility
- Sexually transmitted diseases (STD)

Guideline Category

Counseling

Diagnosis

Management

Prevention

Screening

Treatment

Clinical Specialty

Family Practice

Infectious Diseases

Internal Medicine

Obstetrics and Gynecology

Pediatrics

Intended Users

Advanced Practice Nurses

Health Care Providers

Hospitals

Managed Care Organizations

Nurses

Physician Assistants

Physicians

Public Health Departments

Guideline Objective(s)

- To assist primary care providers to offer the family planning services that will help persons and couples achieve their desired number and spacing of children and increase the likelihood that those children are born healthy.
- To outline how to provide quality family planning services, which include contraceptive services, pregnancy testing and counseling, helping clients achieve pregnancy, basic infertility services, preconception health services, and sexually transmitted disease services

Target Population

Adolescent and adult women, men, and couples

Interventions and Practices Considered

1. Preconception screening, including:
    - Medical history
    - Sexual health assessment
    - Intimate partner violence screening
    - Alcohol, drug and tobacco use assessment
    - Immunizations
    - Depression
    - Body mass index (BMI)
    - Blood pressure
    - Chlamydia
    - Gonorrhea
    - Syphilis
    - Human immunodeficiency virus (HIV)/acquired immune deficiency syndrome (AIDS)
    - Diabetes
2. Contraceptive counseling
    - Establishing and maintaining rapport with client
    - Obtaining clinical and social information from client
    - Working with the client interactively to select contraceptive method
    - Providing a physical assessment related to contraceptive use
    - Providing the contraceptive method along with instructions about correct use
3. Tiered approach to counseling
4. Evidence-based patient education
5. Documentation of patient understanding in medical record
6. Adolescent services
    - Comprehensive information
    - Use of long-acting reversible contraception (LARC)
    - Confidential services
    - Family-child communication
    - Repeat teen pregnancy
7. Contraceptive method availability
8. Youth-friendly services
9. Quality improvement

Major Outcomes Considered

- Rates of unintended pregnancy
- Client behaviors
- Costs of family planning
- Health conditions

Methodology

Methods Used to Collect/Select the Evidence

Hand-searches of Published Literature (Primary Sources)

Hand-searches of Published Literature (Secondary Sources)

Searches of Electronic Databases

Searches of Unpublished Data

Description of Methods Used to Collect/Select the Evidence

Developing Recommendations on Counseling, Adolescent Services, and Quality Improvement

Systematic reviews of the published literature from January 1985 through December 2010 were conducted for each priority topic to identify evidence-based and evidence-informed approaches to family planning service delivery. Standard methods for conducting the reviews were used, including the development of key questions and analytic frameworks, the identification of the evidence base through a search of the published as well as "gray literature" (i.e., studies published somewhere other than in a peer-reviewed journal), and a synthesis of the evidence in which findings were summarized and the quality of individual studies was considered, using the methodology of the USPSTF. Eight databases were searched (i.e., MEDLINE, PsycINFO, PubMed, CINAHL, Cochrane, EMBASE, POPLINE, and the U.K. National Clearinghouse Service Economic Evaluation Database) and were restricted to literature from the United States and other developed countries. Summaries of the evidence used to prepare these recommendations will appear in background papers that will be published separately.

Developing Recommendations on Clinical Services

The Centers for Disease Control and Prevention's (CDC's) Division of Reproductive Health (DRH) and the Office of Population Affairs (OPA) staff members synthesized recommendations for clinical care for women and for men that were developed by >35 federal and professional medical organizations. They were assisted in this effort by staff from OPA's Office of Family Planning Male Training Center and from CDC's Division of Sexually Transmitted Disease (STD) Prevention, Division of Violence Prevention, Division of Immunization Services, and Division of Cancer Prevention and Control.

Number of Source Documents

Not stated

Methods Used to Assess the Quality and Strength of the Evidence

Expert Consensus

Weighting According to a Rating Scheme (Scheme Given)

Rating Scheme for the Strength of the Evidence

Select Panel on Preconception Care Grading System

Quality of the Evidence	
I-a	Evidence was obtained from at least one properly conducted, randomized, controlled trial that was performed with subjects who were not pregnant.
I-b	Evidence was obtained from at least one properly conducted, randomized, controlled trial that was done not necessarily before pregnancy.
II-1	Evidence was obtained from well-designed, controlled trials without randomization.
II-2	Evidence was obtained from well-designed cohort or case-control analytic studies, preferably conducted by more than one center or research group.
II-3	Evidence was obtained from multiple-time series with or without the intervention, or dramatic results in uncontrolled experiments.
III	Opinions were gathered from respected authorities on the basis of clinical experience, descriptive studies and case reports, or reports of expert committees.

Source: Jack B, Atrash H, Coonrod D, Moos M, O'Donnell J, Johnson K. The clinical content of preconception care: an overview and preparation of this supplement. Am J Obstet Gynecol 2008;199(6 Suppl 2):S266–79.

Levels of Certainty Regarding Net Benefit

Level of Certainty*	Description
High	The available evidence usually includes consistent results from well-designed, well-conducted studies in representative primary care populations. These studies assess the effects of the preventive service on health outcomes. This conclusion is therefore unlikely to be strongly affected by the results of future studies.
Moderate	The available evidence is sufficient to determine the effects of the preventive service on health outcomes, but confidence in the estimate is constrained by such factors as • The number, size, or quality of individual studies; • Inconsistency of findings across individual studies; • Limited generalizability of findings to routine primary care practice; and • Lack of coherence in the chain of evidence As more information becomes available, the magnitude or direction of the observed effect could change, and this change may be large enough to alter the conclusion.
Low	The available evidence is insufficient to assess effects on health outcomes is insufficient because of • The limited number or size of studies, • Important flaws in study design or methods, • Inconsistency of findings across individual studies, • Gaps in the chain of evidence, • Findings not generalizable to routine primary care practice, • Lack of information on important health outcomes, or • More information required to allow estimation of effects on health outcomes

Source: US Preventive Services Task Force. USPSTF: methods and processes. Available at http://www.uspreventiveservicestaskforce.org/methods.htm.

*The US Preventive Services Task Force (USPSTF) defines certainty as the likelihood that the USPSTF assessment of the net benefit of a preventive service is correct. The net benefit is defined as benefit minus harm of the preventive service as implemented in a general, primary care population. USPSTF assigns a certainty level on the basis of the nature of the overall evidence available to assess the net benefit of a preventive service.

Methods Used to Analyze the Evidence

Review of Published Meta-Analyses

Systematic Review

Description of the Methods Used to Analyze the Evidence

Developing Recommendations on Counseling, Adolescent Services, and Quality Improvement

In May 2011, three technical panels (one for each priority topic) comprising subject matter experts were convened to consider the quality of the evidence and suggest what recommendations might be justified on the basis of the evidence.

Developing Recommendations on Clinical Services

An attempt was made to apply the Institute of Medicine's (IOM's) criteria for clinical practice guidelines when deciding which professional medical organizations to include in the review. However, many organizations did not articulate the process used to develop the recommendations fully, and many did not conduct comprehensive and systematic reviews of the literature. In the end, to be included in the synthesis, the recommending organization had to be a federal agency or major professional medical organization that represents established medical disciplines. In addition, a recommendation had to be made on the basis of an independent review of the evidence or expert opinion and be considered a primary source that was developed for the United States.

Methods Used to Formulate the Recommendations

Expert Consensus

Description of Methods Used to Formulate the Recommendations

The recommendations were developed jointly under the auspices of Centers for Disease Control and Prevention's (CDC's) Division of Reproductive Health (DRH) and the Office of Population Affairs (OPA), in consultation with a wide range of experts and key stakeholders. A multistage process that drew on established procedures for developing clinical guidelines was used to develop the recommendations. In April 2010, an Expert Work Group (EWG) comprising family planning clinical providers, program administrators, representatives from relevant federal agencies, and representatives from professional medical organizations was created to advise OPA and CDC on the structure and content of the revised recommendations and to help make the recommendations more feasible and relevant to the needs of the field.

Developing Recommendations on Counseling, Adolescent Services, and Quality Improvement

CDC and OPA used the feedback from the three technical panels to develop core recommendations for counseling, serving adolescents, and quality improvement. EWG members subsequently reviewed these core recommendations; EWG members differed from the subject matter experts in that they were more familiar with the family planning service delivery context and could comment on the feasibility and appropriateness of the recommendations as well as on their scientific justification. EWG members met to consider the core recommendations using 1) the quality of the evidence; 2) the positive and negative consequences of implementing the recommendations on health outcomes, costs or cost-savings, and implementation challenges; and 3) the relative importance of these consequences (e.g., the ability of the recommendations to have a substantial effect on health outcomes may be weighed more than the logistical challenges of implementing them). In certain cases, when the evidence was inconclusive or incomplete, recommendations were made on the basis of expert opinion (see Appendix B in the original guideline document). Finally, CDC and OPA staff considered the feedback from EWG members when finalizing the core recommendations and writing this report.

Developing Recommendations on Clinical Services

In July 2011, two technical panels comprising subject matter experts on clinical services for women and men were convened to review the synthesis of federal and professional medical recommendations, reconcile inconsistent recommendations, and provide individual feedback to CDC and OPA about the implications for family planning service delivery. CDC and OPA used this individual feedback to develop core recommendations for clinical services. The core recommendations were subsequently reviewed by EWG members, and feedback was used to finalize the core recommendations and write this report. Members of the technical panels recommended that contraceptive services, pregnancy testing and counseling, services to achieve pregnancy, basic infertility care, sexually transmitted disease (STD) services, and other preconception health services should be considered family planning services. This feedback considered federal statute and regulation, CDC and U.S. Preventive Services Task Force (USPSTF) recommendations for clinical care, and EWG members' opinion.

Determining How Clinical Services Should Be Provided

For determining how clinical services should be provided, various federal agencies and professional medical associations have made recommendations for how to provide family planning services. When considering these recommendations, the EWG used the following hierarchy:

- Highest priority was given to CDC guidelines because they are developed after a rigorous review of scientific evidence. CDC guidelines tailor recommendations for higher risk individuals, (whereas USPSTF focuses on average risk individuals), who are more representative of the clients seeking family planning services.
- When no CDC guideline existed to guide the recommendations, the relevant USPSTF A or B recommendations (which indicate a high or moderate certainty that the benefit is moderate to substantial) were used. USPSTF recommendations are made on the basis of a thorough review of the available evidence.
- If neither a CDC nor a USPSTF A or B recommendation existed, the recommendations of selected major professional medical associations were considered as resources. The American Academy of Pediatrics' (AAP) Bright Futures guidelines were used as the primary source of recommendations for adolescents when no CDC or USPSTF recommendations existed.
- For a limited number of recommendations, there were no federal or major professional medical recommendations, but the service was recommended by EWG members on the basis of expert opinion for family planning clients.

Rating Scheme for the Strength of the Recommendations

Select Panel on Preconception Care Grading System

Strength of the Recommendation	
A	There is good evidence to support the recommendation that the condition be considered specifically in a preconception care evaluation.
B	There is fair evidence to support the recommendation that the condition be considered specifically in a preconception care evaluation.
C	There is insufficient evidence to recommend for or against the inclusion of the condition in a preconception care evaluation, but recommendation to include or exclude may be made on other grounds.
D	There is fair evidence to support the recommendation that the condition be excluded in a preconception care evaluation.
E	There is good evidence to support the recommendation that the condition be excluded in a preconception care evaluation.

Source: Jack B, Atrash H, Coonrod D, Moos M, O'Donnell J, Johnson K. The clinical content of preconception care: an overview and preparation of this supplement. Am J Obstet Gynecol 2008;199(6 Suppl 2):S266–79.

U.S. Preventive Services Task Force (USPSTF) Grades, Definitions, and Suggestions for Practice

Grade	Definition	Suggestions for Practice
A	USPSTF recommends the service. There is high certainty that the net benefit is substantial.	This service should be offered or provided.
B	USPSTF recommends the service. There is high certainty that the net benefit is moderate, or there is moderate certainty that the net benefit is moderate to substantial.	This service should be offered or provided.
C	Clinicians may provide this service to selected patients depending on individual circumstances. However, for a majority of persons without signs or symptoms there is likely to be only a limited benefit from this service.	This service should be offered or provided only if other considerations support the offering or providing the service in an individual patient.
D	USPSTF recommends against the service. There is moderate or high certainty that the service has no net benefit or that the harms outweigh the benefits.	Use of this service should be discouraged.
I Statement	USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of the service. Evidence is lacking, of poor quality, or conflicting, and the balance of benefits and harms cannot be determined.	The clinical considerations section of USPSTF recommendation statement should be consulted. If the service is offered, patients should be educated about the uncertainty of the balance of benefits and harms.

Source: US Preventive Services Task Force. USPSTF: methods and processes. Available at http://www.uspreventiveservicestaskforce.org/methods.htm.

Cost Analysis

A formal cost analysis was not performed and published cost analyses were not reviewed.

Method of Guideline Validation

External Peer Review

Internal Peer Review

Description of Method of Guideline Validation

Not stated

Evidence Supporting the Recommendations

Type of Evidence Supporting the Recommendations

The type of evidence supporting the recommendations is identified for each recommendation (see the "Major Recommendations" field).

Benefits/Harms of Implementing the Guideline Recommendations

Potential Benefits

- Removing medical barriers to contraceptive use is key to increasing access to contraception and helping clients prevent unintended pregnancy. Consistent use of contraceptives is needed to prevent unintended pregnancies, so appropriate counseling is critical to ensure clients make the best possible choice of methods for their unique circumstances, and are supported in continued use of the chosen method.
- The benefits of informing adolescents about all ways to prevent pregnancy are substantial. Ultimately, each adolescent should make an informed decision that meets her or his unique circumstances, based on the counseling provided by the provider.

See the "Potential consequences" and "Rationale" sections for each recommendation for an assessment of benefits and harms of specific interventions.

Potential Harms

See the "Potential consequences" and "Rationale" sections for each recommendation for an assessment of benefits and harms of specific interventions.

Qualifying Statements

Qualifying Statements

- The recommendations are designed to guide general clinical practice; however, health-care providers always should consider the individual clinical circumstances of each person seeking family planning services. Similarly, these recommendations might need to be adapted to meet the needs of particular populations, such as clients who are human immunodeficiency virus (HIV)-positive or who are substance users.
- Use of trade names and commercial sources is for identification only and does not imply endorsement by the U.S. Department of Health and Human Services.
- References to non-Centers for Disease Control and Prevention (CDC) sites on the Internet are provided as a service to MMWR readers and do not constitute or imply endorsement of these organizations or their programs by CDC or the U.S. Department of Health and Human Services. CDC is not responsible for the content of these sites. URL addresses listed in MMWR were current as of the date of publication.

Implementation of the Guideline

Description of Implementation Strategy

An implementation strategy was not provided.

Implementation Tools

Clinical Algorithm

Foreign Language Translations

Patient Resources

Resources

Staff Training/Competency Material

For information about availability, see the *Availability of Companion Documents* and *Patient Resources* fields below.

Institute of Medicine (IOM) National Healthcare Quality Report Categories

IOM Care Need

Staying Healthy

IOM Domain

Effectiveness

Patient-centeredness

Identifying Information and Availability

Bibliographic Source(s)

Gavin L, Moskosky S, Carter M, Curtis K, Glass E, Godfrey E, Marcell A, Mautone-Smith N, Pazol K, Tepper N, Zapata L, Centers for Disease Control and Prevention (CDC). Providing quality family planning services: recommendations of CDC and the U.S. Office of Population Affairs. MMWR Recomm Rep. 2014 Apr 25;63(RR-04):1-54. [364 references] PubMed

Adaptation

Not applicable: The guideline was not adapted from another source.

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Guideline Committee

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Financial Disclosures/Conflicts of Interest

Centers for Disease Control and Prevention (CDC), our planners, content experts, and their spouses/partners wish to disclose that they have no financial interests or other relationships with the manufacturers of commercial products, suppliers of commercial services, or commercial supporters. Planners have reviewed content to ensure there is no bias.

Guideline Status

This is the current release of the guideline.

Guideline Availability

Electronic copies: Available from the Centers for Disease Control and Prevention (CDC) Web site .

Print copies: Available from the Centers for Disease Control and Prevention, MMWR, Mailstop E-90, CDC, 1600 Clifton Rd., N.E., Atlanta, GA 30329-4027 or to mmwrq@cdc.gov. Additional copies can be purchased from the Superintendent of Documents, U.S. Government Printing

Office, Washington, DC 20402; (202) 512-1800.

Availability of Companion Documents

A variety of resources on contraception, including information on reversible and permanent methods of birth control, are available from the Centers for Disease Control and Prevention (CDC) Web site .

A continuing education activity is also available from the CDC Web site .

Patient Resources

The following are available:

- Birth control methods fact sheet. Centers for Disease Control and Prevention (CDC); 2011 Nov. 13 p. Electronic copies: Available in Portable Document Format (PDF) in English and Spanish from the Centers for Disease Control and Prevention (CDC) Web site.
- Emergency contraception (emergency birth control) fact sheet. Centers for Disease Control and Prevention (CDC); 2011 Nov. 4 p. Electronic copies: Available in PDF in English and Spanish from the CDC Web site.

Please note: This patient information is intended to provide health professionals with information to share with their patients to help them better understand their health and their diagnosed disorders. By providing access to this patient information, it is not the intention of NGC to provide specific medical advice for particular patients. Rather we urge patients and their representatives to review this material and then to consult with a licensed health professional for evaluation of treatment options suitable for them as well as for diagnosis and answers to their personal medical questions. This patient information has been derived and prepared from a guideline for health care professionals included on NGC by the authors or publishers of that original guideline. The patient information is not reviewed by NGC to establish whether or not it accurately reflects the original guideline's content.

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